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ALEXANDER L. STEVAS,
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No. ____

IN THE
Supreme Court of the United States

OCTOBER TERM, 1984

ST. MARYS HOSPITAL MEDICAL CENTER,
Petitioner

v

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES,
Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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QUESTION PRESENTED FOR REVIEW

Does a party's out of time post-judgment motion toll the period during which the moving party can institute an appeal from that judgment, when the district court improperly entertains the untimely motion?

Parties to the Action

Petitioner is St. Marys Hospital Medical Center. Petitioner's corporate parent is Sisters of St. Mary. Respondent is Margaret M. Heckler, Secretary of Health and Human Services.

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OPINIONS BELOW

The opinion of the Court of Appeals for the Seventh Circuit is reported at 753 F.2d 1362 (7th Cir. 1985) and is reprinted in the Appendix hereto (App. 1). The memoranda and orders of the District Court for the Western District of Wisconsin (App. 25) and the decision of the Provider Reimbursement Review Board (App. 43) are also set forth in the Appendix.

JURISDICTION

The judgment of the Court of Appeals for the Seventh Circuit sought to be reviewed was issued and entered on January 22, 1985. On February 6, 1985, Petitioner filed a suggestion for rehearing in banc, and, on February 7, 1985, a motion to file a suggestion for rehearing in banc out of time. On February 13, 1985, the court granted Petitioner's motion to file a suggestion for rehearing in banc out of time. However, on March 1, 1985, Petitioner's suggestion for rehearing in banc was denied. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

RULES INVOLVED

Rules of Civil Procedure

Rule 59(e)

> Motion to Alter or Amend Judgment. A motion to alter or amend the judgment shall be served not later than 10 days after entry of the judgment.

Rules of Appellate Procedure

Rule 4. Appeal as of Right – When Taken

(a) Appeals in Civil Cases.

(1) In a civil case in which an appeal is permitted by law as of right from a district court to a court of appeals the notice of appeal required by Rule 3 shall be filed with the clerk of the district court within 30 days after the date of entry of the judgment or order appealed from; but if the United States or an officer or agency thereof is a party, the notice of appeal may be filed by any party within 60 days after such entry. If a notice of appeal is mistakenly filed in the court of appeals, the clerk of the court of appeals shall note thereon the date on which it was received and transmit it to the clerk of the district court and it shall be deemed filed in the district court on the date so noted.

(2) Except as provided in (a)(4) of this Rule 4, a notice of appeal filed after the announcement of a decision or order but before the entry of the judgment or order shall be treated as filed after such entry and on the day thereof.

(3) If a timely notice of appeal is filed by a party, any other party may file a notice of appeal within 14 days after the date on which the first notice of appeal was filed, or within the time otherwise prescribed by this Rule 4(a), whichever period last expires.

(4) If a timely motion under the Federal Rules of Civil Procedure is filed in the district court by any party: (i) for judgment under Rule 50(b); (ii) under Rule 52(b) to amend or make additional findings of fact, whether or not an alteration of the judgment would be required if the motion is granted; (iii) under Rule 59 to alter or amend the judgment; or (iv) under Rule 59 for a new trial, the time for appeal for all parties shall run from the entry of the order denying a

new trial or granting or denying any other such motion. A notice of appeal filed before the disposition of any of the above motions shall have no effect. A new notice of appeal must be filed within the prescribed time measured from the entry of the order disposing of the motion as provided above. No additional fees shall be required for such filing.

(5) The district court, upon a showing of excusable neglect or good cause, may extend the time for filing a notice of appeal upon motion filed not later than 30 days after the expiration of the time prescribed by this Rule 4(a). Any such motion which is filed before expiration of the prescribed time may be ex parte unless the court otherwise requires. Notice of any such motion which is filed after expiration of the prescribed time shall be given to the other parties in accordance with local rules. No such extension shall exceed 30 days past such prescribed time or 10 days from the date of entry of the order granting the motion, whichever occurs later.

(6) A judgment or order is entered within the meaning of this Rule 4(a) when it is entered in compliance with Rules 58 and 79(a) of the Federal Rules of Civil Procedure.

STATEMENT OF THE CASE

This controversy commenced when Petitioner St. Marys Medical Center ("St. Marys") appealed certain adjustments made to its 1978 and 1979 Medicare cost reports to the Provider Reimbursement Review Board ("PRRB"), the component of the Department of Health and Human Services charged with hearing such appeals. The PRRB rejected St. Marys' claims that the disputed adjustments were contrary to the Medicare Act and implementing regulations. St. Marys appealed the PRRB's decision to the United States District Court for the Western District of Wisconsin pursuant to 42 U.S.C. § 1395oo(f). By judgment entered December 30, 1983, the district court reversed the PRRB decision and remanded the action to the PRRB for further proceedings.

On January 9, 1984, the Secretary of the Department of Health and Human Services ("Secretary") filed a motion for reconsideration or clarification of the district court's decision. Although the motion was timely filed, the Secretary's motion was not served on counsel for St. Marys. (App. 6.) On January 16, 1984, the district court denied the Secretary's motion. Upon receipt of a copy of the district court's Order, counsel for St. Marys sent a letter to the district judge thanking him for his decision and informing him that counsel for St. Marys had been unaware of the " 'request for reconsideration as we were never furnished a copy of the Secretary's motion' ". (App. 7, n.8). A copy of that letter was mailed simultaneously to counsel for the Secretary. Notice of Appeal was filed by the Secretary on March 15, 1984, 66 days after the district court's judgment had been entered.

St. Marys argued below that the Secretary's post-judgment motion was untimely because it was not served within ten days of entry of the district court's judgment as required by Rule 59(e) of the Federal Rules of Civil Procedure.

As a result, it did not toll the period during which the Secretary could institute an appeal from the district court's judgment. Because the Secretary's notice of appeal was filed more than sixty days after entry of judgment, it was untimely and the appeal should be dismissed.

The court of appeals recognized that the Secretary's post-judgment motion was untimely and did not toll the appeal period. As a result, her appeal was untimely. However, the court held that the Secretary's appeal should not be dismissed pursuant to this Court's holding in *Thompson v. Immigration and Naturalization Service,* 375 U.S. 384 (1964) (per curiam) (5-4 decision) and its seventh circuit progeny, *Textor v. Board of Regents of Northern Illinois University,* 711 F. 2d 1387 (7th Cir. 1983). According to the court below, *Thompson* required it to hear the appeal because the district judge gave the Secretary implicit assurance that her motion was timely by issuing a memorandum and order explaining his ruling denying reconsideration and by not retracting that order *sua sponte* once St. Marys' counsel advised him of the lack of service. (App. 7-8). The court of appeals then reversed the district court's decision.

REASONS FOR GRANTING THE WRIT

The court of appeals' decision is contrary to the holdings of other courts which have indicated that such "implicit assurance" by a district court that a post-judgment motion is timely is insufficient to invoke this Court's holding in *Thompson*. These courts have recognized that the exception to the general rule requiring timely appeals set forth in *Thompson* is inapplicable in the absence of explicit assurances by the district court to the moving party that the party's post-judgment motion was timely, allowing the party to

reasonably presume that the motion also tolled the appeal period. These courts have also recognized that *Thompson* should not be applied merely because a district court erroneously entertains an out of time motion.

The court of appeals' decision in the case at bar confirms that although over two decades have passed since *Thompson* was decided, considerable confusion remains among the lower courts as to its scope and applicability and that some courts are invoking *Thompson* to save untimely appeals in situations which are far different from the "unique circumstances" addressed by this Court. *See, e.g., Webb v. Department of Health and Human Services,* 696 F. 2d 101 (D.C. Cir. 1982) (moving party could reasonably rely on entertainment of post-judgment motion for attorneys' fees as confirmation that motion came within Rule 59(e) and, therefore, tolled appeal period). Moreover, as discussed below, the lower court's decision effectively shifts the responsibility with respect to compliance with federal rules requiring timely post-judgment motions and the determination of the effect of out of time motions from litigants to the court. In accordance with the court of appeals' decision, if the district court entertains a post-judgment motion, a litigant may presume that the motion was timely and need not make its own independent analysis.

St. Marys respectfully submits that this case presents an important and recurring question of federal law. Accordingly, the Supreme Court should grant certiorari to define the parameters of its holding in *Thompson* and clarify its implications with respect to the general rule that litigants, not the court, are solely responsible for protecting their appeal rights through compliance with applicable procedural rules.

I. *The Issue Involves the Requisite Public Importance to Litigants and Courts Throughout the Nation*

This Court has recognized that the appeal period set forth in Rule 4(a) of the Rules of Appellate Procedure is

"mandatory and jurisdictional." *Browder v. Director,* 434 U.S. 257, 258 (1978). Rule 4(a) provides that the filing of one of four post-judgment motions tolls the appeal period. However, out of time post-judgment motions do not interrupt the appeal period. *Browder,* 434 U.S. at 264-265.

In the case at bar, the court of appeals properly recognized that the Secretary's motion was functionally a motion under Rule 59(e), one of the post-judgment motions, which, if timely, tolls the appeal period. A Rule 59(e) motion is not timely unless "*served* not later than 10 days after entry of the judgment." Fed. R. Civ. P. 59(e) (emphasis added). Accordingly, because the Secretary's motion was never served and her appeal was instituted more than 60 days after entry of the district court's judgment, but for the application of the *Thompson* exception, the Secretary's motion would not have tolled the appeal period and her appeal would have been untimely.

In *Thompson,* a majority of this Court recognized a narrow exception to the general rule that a non-timely post-judgment motion does not toll the appeal period. In that case, the moving party made two out of time post-judgment motions. "The [non-moving party] Government raised no objection as to the timeliness of these motions, and the trial court specifically declared that the 'motion for a new trial' was made in 'ample time.' " 375 U.S. at 384. Although the appeal was instituted more than 60 days after the entry of judgment, the Court found that assumption of jurisdiction by the court of appeals fit "squarely within the letter and spirit" of its earlier decision in *Harris Truck Lines, Inc. v. Cherry Meat Packers, Inc.,* 371 U.S. 215 (1962) where it held that a litigant should not be penalized for relying on a trial judge's order extending the filing date for appeal on the grounds of excusable neglect.

> Here, as there, petitioner did an act which, if properly done, postponed the deadline for the filing of his appeal. Here, as there, the District Court concluded that the act had been properly done. Here, as there, *the petitioner relied on the statement of the District Court* and filed the appeal within the assumedly new deadline but beyond the old deadline. And here, as there, the Court of Appeals concluded that the District Court had erred and dismissed the appeal. Accordingly, in view of these "*unique circumstances,*" . . . we grant the writ of certiorari, vacate the judgment, and remand the case to the Court of Appeals so that petitioner's appeal may be heard on the merits.

375 U.S. at 388 (emphasis added). In an opinion joined in by Justices Harlan, Stewart and White, Justice Clark dissented from the majority's decision*.

The court of appeals found the case at bar very similar to *Thompson*. (App. 7.) However, it recognized that the district court had not given the Secretary "explicit assurance that her motion was timely, as occurred in *Thompson*". Relying on its previous decision in *Textor v. Board of Regents of Northern Illinois University*, 711 F.2d 1387, 1390-1391 (7th Cir. 1983), the court incorrectly concluded that "explicit assurance is unnecessary". (App. 7). The court stated that in *Textor*:

> the district court gave the moving party implicit assurance that her motion was timely by considering it

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* Justice Clark observed that the rules clearly provided that only timely post-judgment motions tolled the appeal period and that the time for such post-judgment motions could not be extended by the district court. Justice Clark also found *Harris Truck Lines* inapposite because unlike in that case where the trial court had jurisdiction to entertain an application to enlarge the time for appeal based on "excusable neglect", in *Thompson*, the trial judge had no jurisdiction to pass upon the untimely motions.

> without mentioning any timeliness problem, and opposing counsel failed to raise the issue. The district judge in the instant situation gave the Secretary the same implicit assurance by issuing a six-page memorandum and order explaining his ruling denying reconsideration, and by not retracting that order *sua sponte* once St. Marys' counsel informally advised him of the lack of service.

(App. 7-8).

The court of appeals' decision invoking *Thompson*, essentially because the district court entertained the out of time motion requires courts, not litigants, to insure that parties comply with applicable rules of procedure. While in *Thompson*, a majority of this Court held that it was unfair to penalize litigants for relying on express assurances by the district court, St. Marys respectfully submits that, in all likelihood, it did not anticipate that litigants could find implicit assurance that a post-judgment motion was timely based on the mere entertainment of the non-timely motion. This Court should clarify that *Thompson* should not be construed as broadly as it was construed by the court of appeals in the case at bar and that litigants remain solely responsible for taking actions necessary to invoke the jurisdiction of courts of appeal.

II. *The Decision of the Seventh Circuit in the Case at Bar Conflicts With the Decisions of Several Other Circuit Courts of Appeal.*

St. Marys respectfully submits that in finding authority to invoke *Thompson* in this case, the court of appeals also construed its previous decision in *Textor* far too broadly*. As a result, its decision in this case is in direct conflict with the decisions of other circuit courts of appeal and the opinion of a respected commentator.

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* In *Textor*, plaintiff filed an untimely Rule 59 motion which was denied on grounds unrelated to its timeliness. Then, several days later, the court struck its order and granted plaintiff "time to

In *Alvestad v. Monsanto Co.*, 671 F.2d 908 (5th Cir.), *cert. denied*, 459 U.S. 1070 (1982), plaintiff-appellant moved for new trial 21 days after entry of judgment. Despite the motion's untimeliness, the court held a hearing on her motion before denying it on its merits. Plaintiff-appellant then filed her notice of appeal less than 30 days after denial of the motion, but 61 days subsequent to entry of final judgment. In an attempt to invoke *Thompson*, she argued that the district court heard argument on her motion "one day before expiration of the regular 30-day limit for filing an appeal"; "indicated its awareness that the deadline for appeal was imminent"; and " 'proceeded to make comments which were properly and reasonably construed by the Plaintiffs as indicating that the court would either rule favorably or would rule by the next day so that Plaintiffs could file their notice of appeal' ". *Id.* at 910-11. The court properly refused to invoke *Thompson*:

> Even accepting this version of the hearing . . . , we are not persuaded that it presents "unique circumstances" sufficient to excuse the failure to file a timely appeal. While we willingly have administered the Supreme Court's equitable exception to avoid dismissal of an other-

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file memoranda in support of her Rule 59 motion". 711 F.2d at 1391. The court of appeals held that in light of this explicit action by the district court, it should not dismiss the appeal:

> Plaintiff, understandably, relied upon this in preparing memoranda in support of her motion rather than filing a notice of appeal. The district court erred in considering the motion, but this error should not deprive plaintiff of her right to appeal. Accordingly, we believe that the facts of this case are within the *Thompson* exception. . . . *Id.*

Thus, in *Textor*, the district court's actions upon which the moving party relied in presuming that her post-judgment motion was timely went far beyond the mere entertainment of the out of time motion.

> wise tardy appeal, we have done so only when the words or actions of the district court clearly mislead the aggrieved party into believing that the filing of an appeal within the thirty day deadline was unnecessary.

Id. at 911. Similarly, in *Fassler v. Moran*, 576 F. 2d 1372 (9th Cir. 1978) (per curiam), the court held that an out of time post-judgment motion did not toll the appeal period even though it was entertained and denied by the court prior to the expiration of the moving party's time for appeal; and the party noted an appeal within 30 days of the court's order denying post-judgment relief.

Other courts have also dismissed appeals because of out of time post-judgment motions which were entertained by the district court. *See, e.g., Browder v. Director*, 434 U.S. 257 (1978); *In re 6 & 40 Investment Group, Inc. v. National City Bank of Cleveland*, 752 F.2d 515 (10th Cir. 1985); *Glass v. Seaboard Coast Line Railroad Co.*, 714 F.2d 1107 (11th Cir. 1983); *Jester v. United States*, 714 F. 2d 97 (11th Cir. 1983) (per curiam); *Sutherland v. ITT Continental Baking Co.*, 710 F. 2d 473 (8th Cir. 1983); *de la Fuente v. Central Electric Cooperative, Inc.*, 703 F. 2d 63 (3d Cir. 1983) (per curiam); *Fox v. Brewer*, 620 F. 2d 177 (8th Cir. 1980); *Merrell-National Laboratories, Inc. v. Zenith Laboratories, Inc.*, 579 F. 2d 786 (3d Cir. 1978); *Saunders v. Cabinet Makers & Millmen*, 549 F. 2d 1216 (9th Cir. 1977) (per curiam). *See also Martinez v. Trainor*, 556 F.2d 818, 821 (7th Cir. 1977) ("district court's assuming to hear and determine a belated motion for a new trial cannot thereby affect the finality of the judgment and enlarge the time for taking an appeal").

Similarly, after noting that *Thompson* has generally "been very narrowly applied," Professor Moore states: "It is clear . . . that the mere fact that the motion is filed prior to the running of appeal time and entertained by the district

court does not postpone the time for appeal". 9 J. Moore, Moore's Federal Practice, ¶204.12[2] at 4-75-4-76 (2d ed. 1985).

Petitioner respectfully submits that because the issue arising out of the case at bar is a recurring one and, additionally, has broad implications beyond the factual setting presented herein, it is appropriate for this Court to further develop the criteria set forth in *Thompson* to insure its fair and consistent application by the courts of appeal.

CONCLUSION

For the foregoing reasons, this petition for a writ of certiorari should be granted.

Respectfully submitted,

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In the

United States Court of Appeals

For the Seventh Circuit

No. 84-1443

ST. MARYS HOSPITAL MEDICAL CENTER,

Plaintiff-Appellee,

v.

MARGARET M. HECKLER, Secretary, Department of Health and Human Services,

Defendant-Appellant.

Appeal from the United States District Court
for the Western District of Wisconsin.
No 83 C 445—John C. Shabaz, *Judge*.

ARGUED NOVEMBER 16, 1984—DECIDED JANUARY 22, 1985

Before CUMMINGS, *Chief Judge*, ESCHBACH, *Circuit Judge*, and SWYGERT, Senior *Circuit Judge*.

CUMMINGS, *Chief Judge*. This appeal arises from the challenge by St. Marys Hospital Medical Center ("St. Marys") to the Secretary of Health and Human Services' (the "Secretary") method of calculating St. Mary's apportionment of laboratory costs between Medicare and non-Medicare patients under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* ("Medicare"). The district court found in favor of St. Marys. We reverse.

I

St. Marys is a short-term acute-care hospital located in Madison, Wisconsin. In 1972 it introduced a program, later known as Shared Laboratory Services ("SLS"), that was designed to spread the hospital's fixed laboratory costs. Through SLS, St. Marys, in cooperation with Methodist Hospital in Madison, sold laboratory services to non-hospital patients, including private physicians, clinics, and small hospitals. These clients would provide several services that the test-taking procedures required to be done and that St. Marys fulfilled for its own patients, *viz.*, ordering the tests, drawing and processing the sample, recording the test results in the patient's records. SLS provided its own courier service to transport samples to be tested and Methodist Hospital billed the SLS clients. The two hospitals shared the expenses of these two activities. St. Marys states that its SLS fees are lower than those it charges its own patients because of competition with commercial laboratories and allegedly lower costs (Br. 6). St. Marys admits that the costs of the SLS program exceed the revenue derived from it (*id.* at 30 n.21.)[1]

Medicare reimburses St. Marys for the laboratory services provided Medicare patients by determining first the ratio of Medicare charges to total charges, and then multiplying total costs by that ratio. Thus if Medicare patients account for thirty percent of the laboratory's charges, then Medicare will reimburse the hospital thirty percent of its laboratory's total costs.[2] This formula as-

[1] SLS is nonetheless profitable for St. Marys because the revenues exceed the program's marginal costs, which are quite low.

[2] This scheme of reimbursement is the one applicable to 1978 and 1979, the cost years at issue. Congress has since radically changed the Medicare reimbursement system for cost years beginning after October 1, 1983. Pub. L. 98-21, Title VI. This new law does not affect the two years before us on this appeal.

sumes that the ratio of Medicare charges to total charges equals that of Medicare costs to total costs. To protect the integrity of this assumption, the Secretary requires a provider to "gross-up" any discounted charges to the level of the regular charges made to all other paying patients before the hospital calculates the ratio of Medicare charges to other charges. Not doing so would mean that total charges would equal less than would otherwise be the case, so that Medicare charges would comprise a larger percentage of the total, resulting in Medicare's bearing a disproportionately heavy burden of the laboratory's cost.

In 1978, St. Marys attempted to account for SLS' lower charges by revenue offset, subtracting SLS revenues from total laboratory costs and total charges before calculating the ratio of Medicare charges to other charges.[3] The intermediary[4] overseeing St. Marys' Medicare reimbursement refused to accept this method, requiring St. Marys to gross-up SLS charges instead. In 1979, St. Marys calculated the ratio of Medicare charges to total charges by including SLS revenues at their actual and not their grossed-up level. Again the intermediary disallowed this approach and required St. Marys to gross-up the SLS charges. In both years St. Marys justified its action by claiming that the SLS services were not similar to tests provided hospital patients, so that grossing-up was unwarranted. Moreover, St. Marys claimed that SLS

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[3] St. Marys had used this method of accounting for the SLS costs since the institution of the program in 1972, evidently with the belief that revenue received from SLS exceeded its costs (Administrative Record ("A.R.") 212-214). This assumption was in error (*id.* at 213), but years prior to 1978 are not at issue in the current appeal.

[4] The Secretary often contracts with private organizations known as "fiscal intermediaries" to reimburse providers their Medicare costs. 42 U.S.C. § 1395h. The intermediary in this case was Blue Cross Association/Blue Cross/Blue Shield United of Wisconsin.

services cost less than did the same tests provided to its patients.

St. Marys appealed both the 1978 and 1979 adjustments to the Provider Reimbursement Review Board ("PRRB" or the "Board"). The hospital also retained Ernst & Whinney, a national accounting firm, to conduct an industrial engineering work-measurement study to ascertain whether St. Marys could document both of its assertions—that the SLS services were markedly different from, and substantially less expensive than, tests provided its patients. The PRRB rejected the Ernst & Whinney study as neither accurate nor verifiable and dismissed St. Marys' objections. The Secretary did not appeal this decision, so that it became the final administrative decision. St. Marys appealed to federal district court under 42 U.S.C. § 1395oo(f)(1). The trial court reversed the PRRB in a judgment entered December 30, 1983. Although agreeing that the Ernst & Whinney study was inaccurate "in some respects" (Mem. Order of Dec. 24, 1983 at 2),[5] it found that SLS costs in fact were always less than those of tests for hospital patients. The court remanded to the PRRB, ordering it to resolve any inaccuracies in St. Marys' study and to apply a method of cost apportionment that would not require grossing-up SLS charges. The Secretary filed a motion for reconsideration on January 9, 1984, but the trial court reaffirmed its decision on January 17, 1984. Notice of appeal was filed in this Court on March 15, 1984. We reverse.

II

Plaintiff contends that the Secretary's notice of appeal was untimely because her motion for reconsideration

[5] The docket entries show that the judgment, although dated December 24, 1983, was not entered until six days later. Copies were mailed to counsel on December 29, 1983.

did not seek specific relief, and, even if requisite specificity was present, it was not timely served. Fed. R. App. P. 4(a)(1) permits the government sixty days in which to file an appeal from a judgment. The filing of one of four post-judgment motions tolls this period.[4] Our jurisdiction depends on the adequacy of the motion for reconsideration filed by the Secretary.

Plaintiff misunderstands the substantive requirements for a Rule 59 motion. The motion need only be in writing, specify the grounds on which the motion is based, and request relief. Fed. R. Civ. P. 7(b)(1); *Martinez v. Trainor*, 556 F.2d 818, 819-820 (7th Cir. 1977). Even if the federal rules required that the requested relief as well as the grounds for it be set forth with specificity, the Secretary's instant motion meets these requirements. St. Marys' reliance on *Western Transportation Co. v. E. I. Du Pont de Nemours and Co.*, 682 F.2d 1233 (7th Cir. 1982), is misplaced, for that case deals with the particularity of grounds for relief, not the specificity of the relief requested. In *Western Transportation*, the disputed motion asked the district court to reexamine its dismissal of some of the moving party's claims, without delineating any reasons whatsoever for the request. In contrast, the motion at issue here identified two specific errors in reasoning that the Secretary believed the trial court had made. The motion also requested that if the trial judge did not agree with the Secretary's interpretation, the district court either modify or clarify its remand order. Supp. App. 3-5. As such, the motion detailed both the action it requested and the reasons for its request, thus falling well within the specificity requirements of the federal rules.

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[4] The four post-judgment motions include a motion for judgment n.o.v. under Rule 50(b); a motion to amend or make additional findings of fact under Rule 52(b); a motion to alter or amend the judgment under Rule 59(e); or a motion for a new trial under Rule 59. All four motions must be initiated within ten days of entry of judgment.

Since the motion made does request "that the judgment be altered or amended," *Western Transportation*, 682 F.2d at 1236, it falls within the intent of Fed. R. Civ. P. 59(e). The critical factor in classifying a motion under Rule 59 is whether "the motion questioned the substantive validity of the judgment and not merely its form," *St. Paul Fire and Marine Insurance Co. v. Continental Casualty Co.*, 684 F.2d 691, 694 (10th Cir. 1982). The Secretary fashioned her motion as falling within Fed. R. Civ. P. 52(b) rather than Rule 59(e) (Supp. App. 2 n.1), but that fact is not dispositive. *Browder v. Director*, 434 U.S. 257, 261-262 n.5. "'Any motion that draws into question the correctness of the judgment is functionally a motion under Civil Rule 59(e), whatever its label.'" *United States v. City of Chicago*, 631 F.2d 469, 474 (7th Cir. 1980) (quoting 9 Moore's Federal Practice ¶ 204.12[1], at 4-67 (2d ed. 1980)).

The more serious objection is that involving service. The Secretary concedes that through inadvertence her motion for reconsideration was not served on opposing counsel, though it was timely filed (Reply Br. 20). We assume *arguendo* that the motion would have had to have been both filed and served before it would have been timely for purposes of Fed. R. App. P. 4(a)(1). Nonetheless, the exception the Supreme Court enunciated in *Thompson v. Immigration and Naturalization Service*, 375 U.S. 384 (*per curiam*), applies here.[7] In *Thompson* the Rule

[7] The Secretary has urged us to extend to her motion our holding in *Hahn v. Becker*, 551 F.2d 741, 744 (1977), that a Rule 50(b) motion filed but not served within ten days was timely. This holding was premised on the language of Rule 50(b), which speaks in terms of a party who has "move[d] to have the verdict and any judgment entered thereon set aside." Both Rules 52 and 59 require motions to be "made" within ten days to be timely. *Hahn* itself refused to decide whether its holding could be extended to a Rule 52(b) motion. In view of our decision that the *Thompson* exception applies, it is unnecessary to answer whether *Hahn* and the Federal Rules would justify the extension to the present motion that the Secretary requests.

59 motion at issue was untimely because it was filed and served more than ten days after entry of judgment.[5] The notice of appeal filed in the case would have been timely had the post-judgment motion tolled the appeals period. Opposing counsel did not object to the motion and the district court explicitly informed the moving party that its motion for a new trial was timely. In these circumstances, the Supreme Court refused to find that the court of appeals lacked jurisdiction and ordered it to hear the case on the merits. *Id.* at 386-387.

The case before us is very similar. A post-judgment motion was filed that would have been timely had it been served. The Secretary's notice of appeal also would have been timely had the post-judgment motion tolled the appeals period. In addition, the opposing party took no formal action cognizable by the court to oppose the Secretary's motion.[6] The district court gave the Secretary no explicit assurance that her motion was timely, as occurred in *Thompson*, but explicit assurance is unnecessary. In *Textor v. Board of Regents of Northern Illinois University*, 711 F.2d 1387, 1390-1391 (1983), we applied the *Thompson* exception to a motion that was both filed and served seven days late. There the district court gave the moving party implicit assurance that her motion was timely by considering it without mentioning any timeliness problem, and opposing counsel failed to raise the issue. The district judge in the instant situation gave the Secretary the same implicit assurance by issuing a six-page memorandum and

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[6] Counsel for St. Marys did send a letter addressed to the district judge, thanking him for his decision refusing reconsideration and informing him that they had been unaware of the "request for reconsideration as we were never furnished a copy of the Secretary's motion" (Letter of January 25, 1984; Add. 3 to Reply Br.). Because this letter did not seek any relief and was not a motion within the requirements of Fed. R. Civ. P. 7(b)(1), the district court's considering it or its being entered on the docket and included in the record would have been improper. See Fed. R. App. P. 10(a).

order explaining his ruling denying reconsideration, and by not retracting that order *sua sponte* once St. Marys' counsel informally advised him of the lack of service.

Our applying the *Thompson* exception does not prejudice the plaintiff or greatly impose on the policies underlying the federal rules. The Secretary's motion itself met all substantive requirements of specificity and timeliness of filing. Cf. *Martinez v. Trainor, supra* (court rejected party's attempt in effect to extend filing deadline by filing a timely, skeletal motion that specified no grounds for the motion and supplementing the motion with specific grounds after the ten-day deadline had passed). Here the judge below ruled on the motion promptly, and he decided in the plaintiff's favor. The notice of appeal was filed only sixteen days after the deadline that would have applied had the post-judgment motion not been made. If St. Marys wished to object to timeliness, it should have raised that objection within sixty days of entry of the judgment, while the Secretary still had an opportunity either to file a notice of appeal or to request an extension of time in which to file an appeal. Plaintiff's counsel's attempt to capitalize on the Secretary's reliance he helped induce by seeking no relief in his letter to the district judge (see n. 8 *supra*) is hardly commendable. Considering all the circumstances, we hold that the decisions in *Thompson* and *Textor* govern. Because the district court's judgment was final under 28 U.S.C. § 1291 and the notice of appeal was timely under *Thompson* and *Textor*, the motion to dismiss the appeal is denied.

III

The issue for review is the appropriateness of the intermediary's requiring St. Marys to gross-up its SLS charges to the level of its other laboratory charges before

calculating the ratio of Medicare charges to total charges. As explained by the district judge,

> "grossing-up" means that patient charges which are lower than those charged to regular hospital patients, including Medicare patients, are raised to the level of the regular patient charges before apportioning the laboratory charges between Medicare beneficiaries and others * * * so that Medicare reimbursement truly reflects the costs incurred by the provider for Medicare patients.

Mem. Order of Dec. 24, 1983 at 3-4.

We were informed at oral argument that the issue is one of first impression for the circuit courts of appeals.

The Medicare statute permits reimbursement of a participating hospital's reasonable direct and indirect costs necessary to the efficient delivery of health services to Medicare beneficiaries. 42 U.S.C. § 1395f(b)(1). The reimbursed costs should be actual costs, but the statute gives the Secretary wide latitude in developing methods of determining costs. *Id.* § 1395x(v)(1)(A).

The Secretary's regulations must receive great deference as actions of an administrative agency. A court may not invalidate them unless they are unsupported by substantial evidence in the record or are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A), applicable to Medicare by virtue of 42 U.S.C. § 1395oo(f)(1). Methods of reimbursement that shift costs properly allocable to the care of Medicare patients to non-Medicare patients, and vice versa, are impermissible. 42 U.S.C. § 1395x(v)(1)(A). If the Secretary's decision meets these requirements, we cannot overturn it merely because we might have decided differently. *Northwest Hospital, Inc. v. Hospital Service Corp.*, 687 F.2d 985, 990 (7th Cir. 1982).

Medicare regulations do permit providers, under certain circumstances, to use alternatives to orthodox

methodology. The alternative advocated must be demonstrably "more sophisticated." 42 C.F.R. § 405.453(d)(2)(ii). The burden is on the provider to produce verifiable and auditable cost data to persuade the intermediary to accept the alternative methodology. *Id.* § 405.453(a), (c).[9]

The grossing-up requirement has its genesis in 42 C.F.R. § 405.452(d)(6) (1982) (recodified without change in 1983 as § 405.452(b)): "Charges refer to the regular rates for various services which are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services." The Administrator of the Health Care Financing Administration reminded intermediaries in March 1980 in Intermediary Letter 80-8

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[9] These regulations provide in pertinent part:

> (a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding * * *.
>
> * * *
>
> (c) *Adequacy of cost information.* Adequate cost information must be obtained from the provider's records to support payments made for services rendered to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis.

that hospitals should gross-up discounted laboratory charges such as those for the SLS services St. Marys provides in order to avoid cross-subsidization. Supp. App. 96. This directive assumes that the cost of SLS-type services approximates that of the corresponding testing services the hospital provides its regular patients. The hospital's decision to charge its clients less, for reasons of competition or for any other reason, should not affect the cost-apportionment process.[10]

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[10] St. Marys argues that the intermediary's reliance on Intermediary Letter 80-8 was improper because the letter allegedly constitutes a substantive change in Medicare policy and so should have been promulgated and published pursuant to a provision of the Administrative Procedure Act, 5 U.S.C. § 552(a)(1)(D). The hospital also argues that the grossing-up required by the Intermediary Letter is an inappropriate retroactive application of principles established after the cost years at issue. The district court properly rejected both contentions summarily. As Judge Shabaz observed, Intermediary Letter 80-8 is a logical corollary of the definition of charges in Section 405.452(d)(6) of the regulations and as such constituted no new policy (Mem. Order of Dec. 24, 1983 at 8-9).

St. Marys contends further that the question at issue is not one of cost apportionment at all, but of allowance of cost, because the SLS clients are not patients within the meaning of the regulations. But the laboratory testing services provided are allowable costs. The tests themselves do not differ from tests St. Marys provides its patients. The samples on which the tests are performed come from people who are patients elsewhere. Thus St. Marys cannot be allowed to treat the SLS testing costs as non-allowable costs such as television and other luxury items. Nor is SLS analogous to programs in which hospitals may participate that are quite distinct from any service the hospital provides its own patients. Cf. *Monsour Medical Center (Jennett, Penn.) v. Blue Cross and Blue Shield Ass'n/Blue Cross of Western Penn.*, PRRB Dec. No. 84-D133, [4] Medicare and Medicaid Guide (CCH) ¶ 34,138 at 10,105 (1984) (three programs—Drug and Alcohol Program, Driving While Intoxicated Program, Women, Infants and Children Program—operating with their own personnel and facilities found to be "not related to patient

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In order to avoid grossing-up, St. Marys must establish that its SLS services in fact differ from laboratory services provided its own patients, and that the SLS services are less costly.[11] Even if the SLS tests differ from

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[10] *continued*

e services"); *St. Joseph Hospital (North Providence, R.I.) v. Blue Cross and Blue Shield Ass'n/Blue Cross of Rhode Island*, PRRB Dec. No. 84-D126, [4] Medicare and Medicaid Guide (CCH) ¶ 34,126 (1984) (Meals On Wheels Program). Determining whether a cost is allowable or not based on the identity of the patient would cause all costs not associated with St. Marys' Medicare beneficiaries to be disallowed and would destroy the cost apportionment process entirely. Treating the SLS services as services provided to non-Medicare beneficiary patients, and then apportioning the laboratory's total costs between Medicare beneficiaries and non-Medicare beneficiaries, is much more reasonable than treating the services themselves as non-allowable costs.

[11] If SLS testing procedures are similar to those St. Marys provides its patients, then even if they cost less, grossing-up is an appropriate exercise of the Secretary's authority. Exact cost determination is not feasible, and the reimbursement procedures are based on the assumption that the cost of the same procedure will differ from patient to patient, and from some categories of patients to other categories of patients. See *Culpepper Memorial Hospital v. Heckler*, 592 F. Supp. 1173, 1184-1185 (E.D. Va. 1984) (accounting for patients in a hospital's labor/delivery room area; court held existence of counterbalancing distortions justified Secretary's policy); *Alexandria Hospital v. Heckler*, 586 F. Supp. 581, 588-589 (E.D. Va. 1984) (malpractice insurance; court held Secretary had not carried burden of proving that countervailing imbalances did not correct imbalance of which she complained). These varying costs

(Footnote continued on following page)

the tests St. Marys provides its own patients, as long as their cost to the laboratory equals that of the hospital's tests of its patients, grossing-up maintains a constant cost-to-charge ratio.[12] With this ratio the same, the ratio of Medicare charges to total charges will remain constant, and Medicare reimbursement will not be disturbed. Requiring grossing-up in that situation would be rational, and the Secretary's decision could be justified. Only when the cost of a dissimilar service is less than the hospital's service would grossing-up unfairly minimize the amount of reimbursement to which St. Marys would be entitled. Consequently the factor determinative of the acceptability of the Secretary's requiring St. Marys to gross-up its SLS charges is whether a cost differential exists. St. Marys' failure to prove that such a differential existed with an accurate and verifiable cost study justified the adverse PRRB decision. The district court erred in asserting that the PRRB had in fact accepted the existence of a cost differential but was quibbling over minor inaccuracies in St. Marys' study. This logic misinterprets the thrust of the administrative decision.

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[11] *continued*

will average out, and basing Medicare payments on this average by requiring a uniform charge is fair. St. Marys does not challenge grossing-up of similar charges for similar services. The hospital contends instead that SLS is different from the laboratory's other procedures and that it costs less.

[12] *Johns Hopkins Hospital (Baltimore, Md.) v. Blue Cross Assoc./Blue Cross of Maryland, Inc.*, PRRB Dec. No. 81-D62, [1981-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 31,430, is not to the contrary. The PRRB there refused to allow an intermediary to require a hospital to use net Medicaid charges and gross total revenues in determining the Medicare cost-to-charge ratio. Instead both the Medicaid numerator and the total-charges denominator had to be net of blood replacement credits, so that the numbers in the ratio could "compare like statistics, apples to apples, not apples to oranges, if the

(Footnote continued on following page)

The crux of the PRRB's decision was its conclusion "that the Provider's study did not establish the cost of providing services to non-Provider patients for the years 1978 and 1979" (PRRB Dec. 83-D42 at 6). The Board supported this conclusion by noting several discrepancies in the study: both St. Marys and its accounting firm indicated "a lack of confidence that the cost study" accurately reflected the SLS costs; the pathologists' fees were not properly allocated in the cost computation initially submitted to the Board; the Provider never used the results of the study to adjust its charges to either inpatients or SLS patients; the SLS charges had been established on an arbitrary basis, without consistent price mark-ups in later years; and the accounting firm's testimony indicated that SLS revenues were insufficient to meet the costs of the service.

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[12] *continued*

objective of cost apportionment is to be met." *Id.* at 9167. What was discounted from the numerator had to be discounted from the denominator. Thus the case did not address the problem here of a service that was different from another service but cost the same. The PRRB was concerned about the relationship between the mark-up over cost of the SLS charges and the mark-up of the laboratory's corresponding testing charges to its patients. A.R. 205-206, 233-234. The Board was also concerned about possible arbitrariness in the manner in which the hospital increased its SLS charges and possible disregard by St. Marys for a consistent relationship between costs and charges (A.R. 213-215, 245-246).

The problem is one of services where the costs are the same, but the hospital applies a different mark-up over cost, resulting in different prices. Thus cases involving different charges for different and less expensive services, or for differing degrees of services, applied uniformly throughout the hospital are also not to the contrary. In those cases demonstrable differences in costs justified price differences. See, *e.g.*, *Sheppard and Enoch Pratt Hospital v. Blue Cross and Blue Shield Ass'n/Blue Cross of Maryland*, Decision of Administrator, affirming, PRRB Dec. No. 84-D16, [4] Medicare and Medicaid Guide, (CCH) ¶ 33,905 (1984).

Other evidence in the record also supported the PRRB's decision.[13] Thus the Provider's study was conducted specifically to prove that SLS costs were less than laboratory testing St. Marys provided its own patients, suggesting an initial bias in the study. It focused on only one blood test, the SMAC, that accounted for forty-three to forty-six percent of total SLS test volume, thus ignoring the remaining tests that together accounted for the majority of the SLS test volume. It evidently did not properly allocate the costs of the SLS courier service. Ernst & Whinney conducted its study for one week in January four years after the accounting years in issue, from which limited figure it purported to project annual costs accurately. Moreover, the study was never validated by subsequent reviews.[14] The PRRB concluded that the cost computations "would have to be accurate and verifiable before their use could be considered as a more sophisticated method of cost apportionment" (*id.* at 7). This conclusion, coupled to the earlier declaration that the study failed to establish SLS costs, provides a clear negative inference that the Ernst & Whinney study was neither accurate nor verifiable.

The district court agreed with the PRRB that inaccuracies did inhere in the Ernst & Whinney study. The

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[13] Although the PRRB did not cite this evidence specifically in its decision, it did include it in its outline of the intermediary's objections to St. Marys' accounting methods. This evidence was before the Board and reference to it is justified to illustrate that evidence in the record additional to what the Board chose specifically to cite supports the Board's decision. As long as substantial evidence in the record justifies the Board's decision, we must affirm it.

[14] A close reading of testimony in the administrative record by Ernst & Whinney's expert does not justify St. Marys' assertion that the study was verified (A.R. 330-331). See discussion *infra* pages 19-20.

court noted: the costs of the pathologist who supervised the laboratory operation and the costs of supervising the SLS courier services may have been improperly allocated; the costs of collecting specimens may have been overstated; the period of the study may not have been representative of the accounting years at issue; and the costs of tests done on St. Marys' patients at an outside hospital may have been improperly allocated. The court then observed that although "it is arguable that St. Marys' witnesses resolved some or all of these questions, the Board was not obliged to accept the testimony" (Mem. Order of Dec. 24, 1983 at 10). The judge concluded "that the questions were raised and that the evidence of possible inaccuracy is in the record. Thus, the Board's decision concerning inaccuracy cannot be overturned." (*Id.*)

Despite this conclusion, the district court believed that the PRRB had made an implicit finding that SLS costs were cheaper, "in fact were significantly cheaper, to perform than the same tests done for hospital patients" (*id.* at 11). Ernst & Whinney had broken down the one test they examined into twelve steps, of which three steps were technical ones performed by laboratory personnel. St. Marys argues that this single fact establishes that the SLS tests are different and cheaper to perform. Yet the hospital has not provided any information substantiating this assertion. The bulk of the cost of the tests may very well lie in their technical components; the breakdown of the test into component parts alone is not dispositive of cost. St. Marys assiduously avoids mentioning that it shares the costs of four additional steps through the SLS courier service and the hospital's billing arrangements, thus being responsible for the costs of seven of the necessary steps. Until the hospital can prove that such costs as ordering and collecting specimens comprise a significant percentage of the test's total cost and that St. Marys does not in any way bear these costs or their equivalent when SLS testing is involved, the hospital

cannot assert that a cost differential exists. Without a cost differential, grossing-up is of course entirely proper.[15]

Contrary to the assertion of the court below, the existence of a cost differential was very much in issue. St. Marys' claim depends on the cost question, because the hospital justified its argument that the services were dissimilar with the assertion that a cost differential existed. Compare, *e.g.*, St. Marys Br. 25-26 (SLS tests less expensive because fewer steps involved) with *id.* at 28 (tests dissimilar because few steps in common). See also *id.* at 37 ("uniform charges result in an accurate allocation of costs only when there are uniform costs"); A.R. 248 (Mr. LaFrombois, St. Marys' Director of Fiscal Services, testified that St. Marys' position was that cost differential justified charge differential). The necessity of establishing that a cost differential exists rests with the hospital, not with the Board. The district court reasoned that the PRRB reached the question of the accuracy of St. Marys' alternative methodology because the procedures were in fact dissimilar and SLS costs were substantially less. But the PRRB stated explicitly that the cost study "did not establish" SLS costs. This conclusion carries the opposite implication, that St. Marys failed to prove the cost differential on which its argument depends. Therefore, the district court's reasoning must be regarded with suspicion. Nor do we find that the PRRB made the implicit finding that a cost differential existed, as the district court suggests. Once the PRRB found the cost study to be inadequate, no further inquiry was necessary. St. Marys had failed to carry its burden of proving that a cost differential between SLS costs and regular laboratory costs existed. As a result, the agency had no need to

[15] See *supra* n.12 and accompanying and following text. St. Marys' pricing of its SLS program was motivated primarily by competition with commercial laboratories, not by a *bona fide* belief that the services cost less. See, *e.g.*, A.R. 233-234.

address whether the services were similar or dissimilar. Its failure to do so does not indicate that the Board believed a cost differential existed.

St. Marys' difficulty lies in its concession that the costs of the SLS program exceed the revenue SLS produces (Br. 30 n.21).[16] This fact means that revenue offset will not accurately account for SLS costs, as some SLS costs will remain even after the total SLS revenues have been applied. Multiplying the ratio of Medicare charges to total charges by the remaining costs, including some unspecified amount of SLS costs, will result in Medicare's reimbursing St. Marys for some costs for which the program is not responsible. The method of reimbursement St. Marys proposed for 1979 would similarly distort the reimbursement process. The inequality in the cost-to-charge ratio for SLS charges would impermissibly minimize total charges, thereby increasing the ratio of Medicare charges to total charges and causing Medicare again to overreimburse St. Marys. The two remaining alternatives-cost offset and constant cost-to-charge ratio — reduce to the same thing (Secretary's Br. 15-16). Cost offset would require St. Marys to subtract SLS charges and SLS costs from total charges and total costs, respectively, before calculating the Medicare charge to total charge ratio. The second method grosses-up SLS charges until the ratio of SLS charges to SLS costs equals that of other charges to other costs (Secretary's Br. 28). Because both of these approaches rely on the exact cost of SLS services, an inability to determine that figure with sufficient accuracy renders them useless for cost apportionment purposes. St. Marys would be entitled to avoid grossing-up SLS charges and rely on either of these alternatives only when it could prove the extent to which

[16] This concession does not vitiate St. Marys' argument that a cost differential exists. Conceding that revenue does not cover costs is not conceding that SLS costs are less than those of the laboratory testing that St. Marys provides its patients.

SLS costs were less than those of St. Marys' other laboratory tests.

Substantial evidence in the record supports the PRRB's decision that St. Marys failed to carry its assigned burden of proof. A good illustration is one of the examples the PRRB cited as evidence that St. Marys' management lacked requisite confidence in the accuracy of the Ernst & Whinney study. Board member Houdek was questioning Edward LaFrombois, St. Marys' Director of Fiscal Services, concerning the implications for reimbursement when SLS costs exceed SLS revenues, as even the Ernst & Whinney study indicated they did. Mr. LaFrombois initially refused to accept that the revenue offset method would cause Medicare to cross-subsidize the SLS program (A.R. 216). When asked to justify his position, Mr. LaFrombois finally admitted that cross-subsidization would occur, "[a]ssuming that those costs [that the study reflected for 1978 and 1979] are adequately representing the cost of SLS" (*id.* at 217). This qualification caused Mr. Houdek to question Mr. LaFrombois about his confidence in the accuracy of the accountants' cost study, a question Mr. LaFrombois would never answer directly and to which he finally responded "[w]e feel it is an accurate reflection within the state of the art" (*id.* at 217-218). The Board correctly realized that whether the study represented "the state of the art" was not the question. The issue was the study's accuracy, and St. Marys gave the PRRB sufficient reason to refuse to rely on its cost study.[17] St. Marys would vindicate its study by contending "that a number of different tests * * * established that the study was accurate within 1%" (St. Marys' Br. 40). But the testi-

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[17] Board member Dudgeon also brought inaccuracies in the Ernst & Whinney study to light in his questioning of Mr. LaFrombois. See A.R. 237-242. David Shanahan, St. Marys' expert witness on Medicare accounting principles, testified as follows:

(Footnote continued on following page)

mony St. Marys cites to support this claim does not support its assertion. George Whetsall, the management specialist at Ernst & Whinney responsible for the cost study, testified that manipulating their collected data in two different ways yielded results within one percent of each other (A.R. 330-331). He did not testify that later studies verified the cost study, and he did not testify that Ernst & Whinney's underlying assumptions and categorization of the data were correct. Because a study's results are only as reliable as the way in which the study is set up and conducted, Mr. Whetsall's statements are little more than self-serving manipulations of data that may have been fundamentally flawed.

A very different situation appeared in *St. Mary's Medical Center (Knoxville, Tenn.) v. Blue Cross Association/Blue Cross & Blue Shield of Tennessee*, PRRB Dec. No. 79-D79 [1980 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 30,337.[18] The controversy there cen-

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[17] *continued*

Chairman Tierney:	But am I about right? Yours aren't—you don't really know what the costs are. Hell, none of us know what the costs are, do we?
The Witness:	That's right.

A.R. 392.

Mr. Shanahan, like St. Marys' other witnesses, nonetheless continued to assert that whatever the costs, SLS tests were cheaper to perform than the comparable tests St. Marys conducted for its patients.

[18] The Deputy Administrator of the Health Care Financing Administration, acting under authority delegated by the Secretary, affirmed this decision in *St. Mary's Medical Center (Knoxville, Tenn.) v. Blue Cross Assoc./Blue Cross & Blue Shield of Tennessee*, Decision of Administrator, affirming, PRRB Dec. No. 79-D79 [1980 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 30,432.

tered on laboratory services quite similar to the SLS program at issue before us. In that case the Board disapproved of grossing-up. As in the instant situation, the cost study showed that hospital laboratory personnel conducted only two of nine steps involved. The court below used this fact to assert that the cost study in the instant case necessarily proved that SLS services were less expensive than other laboratory tests. The Tennessee case, however, will not withstand such an extension. Two other facts of much greater importance controlled the result reached there. The PRRB explicitly found the cost study to be accurate, a finding completely contrary to the one it reached with regard to the Ernst & Whinney study. The study there also demonstrated that revenue from the program exceeded costs, so that revenue offset was appropriate and a precise cost determination was unnecessary in order to allocate the laboratory's total costs accurately. The district court conceded that the PRRB "correctly" determined "that costs exceeded revenues, thus precluding a revenue offset" (Mem. Order of Dec. 24, 1983 at 13). It relied on *St. Mary's Medical Center (Knoxville)* because it believed that in both cases the hospitals had established a cost differential. The Tennessee hospital was able to do so; St. Marys has failed to do so in the instant case.

Much closer in point than *St. Mary's Medical Center (Knoxville*) is *Lake Region Hospital Corp. v. Heckler*, Civ. 6-82-1052 (D. Minn. Dec. 30, 1983). Again the facts are substantially the same. The main difference is that the PRRB identified an error factor in the Lake Region cost study of as much as twenty-five percent. Although the Board did not quantify an error factor in the instant case, its failure to do so is not fatal. For reasons that are unclear, the district judge determined that the "unverifiable portions" of St. Marys' study were not significant and that "St. Marys clearly established the existence of a cost difference, while Lake Region did not" (Mem. Order

of Jan. 16, 1984 at 3, 2). He apparently assumed from his own assessment of the record that only portions of St. Marys' study were unverifiable, that those portions were insignificant, and that a cost differential had been established. Some evidence in the record might support such an assessment. But the real question is not the assessment the trial judge might be inclined to make but whether substantial evidence in the record supports the determinations made by the PRRB. The failure by the court below to address meaningfully this latter question constitutes reversible error.[19] The PRRB unequivocally stated that the cost study did not establish costs, so that the presence or absence of a cost differential could not have been established either. Substantial evidence in the record indicates that the cost study contained serious flaws. Therefore, the PRRB's refusal to accept it is amply justified. What seems to have influenced the district judge the most in deciding to the contrary was testimony by the intermediary's witness that the intermediary would require St. Marys to

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[19] As a reviewing court, the district court is bound by the same deferential standard of review that binds us and that was discussed *supra* page 9. The district court's failure to affirm the PRRB decision that substantial evidence in the record supported requires us to reverse that decision. Disregarding that substantial evidence in favor of other conflicting evidence was improper, because the conflicting evidence when reviewed in context does not detract from the persuasiveness and weight of the evidence upon which the PRRB relied.

The Secretary also alleges that the district court erroneously considered material outside the administrative record when it allowed St. Marys to include correspondence between an official of the Health Care Financing Administration, Bernard Patashnik, and another Medicare provider. Because the district court did not rely on this letter to reach its decision, but only referred to it as setting forth one possible alternative to grossing-up that the PRRB might require St. Marys to use on remand, we need not decide whether the court below erred in allowing St. Marys to bring the letter to the court's attention.

gross-up charges for tests with the same name, regardless of their respective costs and regardless of whether the services provided were the same or not. Even if this position of the intermediary were error, considering it fails to address the question whether the cost study was sufficiently reliable. St. Marys has not met the burden of proof required by 42 C.F.R. § 405.453(a), (c).[20] Accordingly the district court's judgment is reversed.

A true Copy:
Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

[20] Quoted *supra* n.9.

USCA 50234—Pandick Midwest, Inc., Chicago—1-22-85—450

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ST. MARYS HOSPITAL
MEDICAL CENTER,

Plaintiff, MEMORANDUM
AND ORDER

v. 83-C-445-S

MARGARET M. HECKLER,
Secretary, Department of
Health and Human Services,

Defendant.

Before the Court is the motion of the defendant that the Court reconsider its decision reversing and remanding this matter to the Secretary. The Court, in its decision of December 23, 1983, determined that the Provider Reimbursement Review Board (PRRB) had implicitly held that, although the laboratory services provided by the plaintiff to non-provider patients were less costly than those provided to hospital patients, the plaintiff's cost study contained inaccuracies which required a grossing-up of charges to non-provider patients. This Court held that, because a difference in costs had been established, the Secretary was required by statute to resolve any inaccuracies which required a grossing-up of charges to non-provider patients. This Court held that, because a difference in costs had been established, the Secretary was required by statute to resolve any inaccuracies and, thereafter, apply cost apportionment in such a manner that no cross subsidization of costs occurred.

MEMORANDUM

In support of its motion, the Secretary has submitted the decision of Judge Barrett in *Lake Region Hospital Corporation v. Heckler,* Civ. 6-82-1052, slip opinion, (December 30, 1983, D.C. Minn.). The case was very similar to this case in that it involved a laboratory department which was providing services to non-hospital patients through clinics, services which the hospital contended were less expensive than similar services to hospital patients. This Court discussed the PRRB decision in *Lake Region,* No. 82-D104, at some length in its decision.

While Judge Barrett affirmed the PRRB decision against *Lake Region,* the Court must point out some glaring differences. St. Marys clearly established the existence of a cost difference, while *Lake Region* did not. This Court never suggested, as defendant's motion implies, that there is always a cost differential. Furthermore, Judge Barrett found substantial evidence to support the PRRB finding that the provider's study contained as much as a 25% error factor and that significant portions were not capable of verification. In comparison, St. Marys' study arguably contained errors which were never quantified by the PRRB. The Court cannot credit any claim that the errors in St. Marys' study (which, the Court would point out, had to be gleaned from the record as a whole because the Board's findings were sadly deficient as to specifics) were anywhere near that high.

Furthermore, this Court could not say, based on the record before it, that the unverifiable portions of St. Marys' study were significant. The intermediary's agent who testified before the Board rather pointedly stated that it didn't matter what the study showed because Intermediary Letter 80-8 required grossing-up under any circumstances. When questioned concerning specific problems with the study, he implicitly, and, at times, explicitly stated that the objections

to the study were auditable. This was the testimony upon which the Secretary is bound to rely, and it supports an opposite conclusion from that reached in Lake Region because the intermediary's testimony there is in stark contrast to that offered here. According to Judge Barrett, the intermediary witness testified specifically that the cost data could not be audited or verified because it was arrived at by estimates without documentation. Salaries of x-ray technicians were not properly allocated because the provider's analysis only considered time spent on patient work and, in essence, allocated all other time to hospital patients. This error, according to the witness, may have resulted in a substantial cost distortion.

The contrast between the evidence in *Lake Region* and in this case could hardly be more clear. Evidence which was explicitly stated to be unverifiable (that is, incapable of being subjected to audit) in *Lake Region,* must be compared with the testimony of the intermediary's representative here who all but explicitly stated that the study, while inaccurate in some apparently insignificant respects, could be audited but should not be because it would not make any difference. With regard to this latter contention of the intermediary's witness (that the study's accuracy made no difference), the Court notes that the Board in Lake Region specifically rejected it. *See Lake Region,* slip opinion, page 11, note 3.

The Court must reiterate that the basis of its holding is the Congressional mandate against cross subsidization. 42 U.S.C. § 1395(b)(1)(A). That is the "touchstone." *Northwest Hospital, Inc. v. Hospital Service Corp.,* 687 F.2d 985, 989 (7th Cir. 1982). The Court reads Judge Barrett's decision in *Lake Region* as standing for the proposition that a study purportedly showing a cost differential can be rejected as unverifiable only when the study is so frought with substantial error that there is doubt about the existence of a cost dif-

ferential in the first instance. *Lake Region* is a different case than this one.

A more substantial part of the present motion concerns the procedure on remand. This Court meant to mandate no certain method of cost accounting. The Board is free to hold another hearing, to require additional evidence from the parties, to require the intermediary to audit the study, or to adopt another course altogether. If the Board recognizes a problem with the study that cannot be resolved with requisite accuracy, this Court believes that the Board would be within its authority to reject the study to that extent only and resolve that problem against the party having the burden of proof on the question, that is, the provider. The Board in its decision did not note a problem that appears on its face to be unquantifiable. The Court's decision did not require absolute accuracy; nor does the law require such accuracy. The law merely requires that the Board's decisions not be arbitrary or capricious. The provider will not be heard to complain when the Board makes a reasonable estimate in the cost finding or cost apportionment process.

With regard to cost apportionment, the Court did not mandate a specific method. The Court noted the Madison General Hospital case, PRRB Case No. 81-307, as a settlement which seemed to comply with the Congressional mandate and the regulations. Defendant has noted that the case may be reopened. While the Court may have been misled concerning the finality of that settlement, the Court specifically refused to require a similar cost apportionment procedure.

The Court's decision did not tie the hands of the Secretary and Board with respect to either resolution of problems with the study or resolution of the cost apportionment. There is, therefore, no merit to defendant's motion. Given the establishment of a cost differential and auditable study documen-

tation, the Secretary and the Board must resolve the inaccuracies in the study and apportion costs so that cross subsidization is avoided.

Accordingly,

ORDER

IT IS ORDERED that defendant's motion for reconsideration is DENIED.

Enter this 16th day of January, 1984.

BY THE COURT:

JOHN C. SHABAZ
District Judge

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WISCONSIN

ST. MARYS HOSPITAL MEDICAL CENTER,

Plaintiff,

v.

MEMORANDUM AND ORDER
83-C-445-S

MARGARET M. HECKLER, Secretary, Department of Health and Human Services,

Defendant.

This appeal by the plaintiff seeks to overturn the final administrative decision of the Secretary of the Department of Health and Human Services (hereinafter, "Secretary") which required a "grossing-up" of the charges levied by St. Marys Medical Center (hereinafter "St. Marys" or "hospital") for laboratory services provided to non-hospital patients to the level of charges levied for providing the same services to hospital patients. The "grossing-up" procedure caused a significant decrease in Medicare reimbursement for laboratory services provided to Medicare patients during the years subject to this appeal, 1978 and 1979.

This case arises under 42 U.S.C. § 1395, et seq. and jurisdiction of this Court is predicated upon 42 U.S.C. § 1395oo(f)(1). The facts as they appear from the record are as follows:

FACTS

St. Marys is a short-term, acute-care nonprofit hospital located in Madison, Wisconsin. For some time prior to the years in question, St. Marys was a provider of services to Medicare beneficiaries.

In 1972 St. Marys, in cooperation with Methodist Hospital of Madison, began offering laboratory services to doctors' offices, hospitals and clinics that did not have the resources to perform such services for their patients. The agreement came to be known as "Shared Laboratory Services" ("SLS") in 1976 when the arrangement was formalized. Each hospital continued to provide the laboratory services to their own patients that they were equipped to provide, and each supplied the services to the other that were not available in the other hospital. Services to other clients were provided by operation of a courier service which would transport materials to the appropriate hospital and then take the results of the testing procedures back to the client. The doctors, clinics and hospitals would then be billed for the services by the respective hospitals.

Between 1972 and 1977, St. Marys' accounted for the SLS services, for purposes of Medicare reimbursement for services provided to its own patients, by subtracting the revenues from SLS from the costs of the laboratory department. The remaining costs of the laboratory were then apportioned between Medicare and non-Medicare patients. By virtue of a cost accounting process which can be generously described as unsophisticated, the hospital assumed that the revenues of SLS approximated the hospital's costs for the program. Because of the lack of sophistication in this process, and because the hospital's SLS program was in competition with private, for-profit, testing facilities, it is clear from the record that the costs of the program actually exceeded revenues. The hospital suffered no losses from the process,

however, because equipment and personnel were already in place; thus, the marginal cost to the hospital was extremely low.

However, by failing to properly attribute indirect costs to the program, it is clear that to some unknown extent Medicare reimbursements and other patient charges subsidized the SLS program. For hospital fiscal years 1978 to 1979, Blue Cross-Blue Shield United of Wisconsin, St. Marys Medicare intermediary, refused to accept the above-mentioned cost accounting for purposes of Medicare reimbursement and required that the SLS services be "grossed up" to the level of services to other patients. The term "grossing up" means that patient charges which are lower than those charged to regular hospital patients, including Medicare patients, are raised to the level of the regular patient charges before apportioning the laboratory charges between Medicare beneficiaries and others. In this way, the costs of the laboratory department are, theoretically, spread equitably among users so that Medicare reimbursement truly reflects the costs incurred by the provider for Medicare patients.

The intermediary in this case, Blue Cross-Blue Shield United of Wisconsin, justified its actions by reference to Intermediary Letter 8-80 (see Record, page 535), which was issued by the Health Care Financing Administration (HCFA). In pertinent part, the letter states:

> Charges made for these laboratory services by hospitals to other than their patients are often lower than charges for the same services to hospital patients. Intermediaries are reminded that the lower charges must be grossed-up as part of the cost apportionment process to comply with section 2202.4 of HIM-15-1 (Prov. Reimb. Manual) which states:

> Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the service and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value, i.e. charges before the application of allowances and discount deductions.

Gross-up of these charges is necessary in order to meet the program objective that the cost of delivering services to program beneficiaries will not be borne by nonbeneficiaries, and that the costs with respect to nonbeneficiaries will not be borne by the program.

Intermediaries are instructed to inform hospitals that uniform charges for similar hospital services must be recorded for the purpose of cost apportionment.

Intermediaries are further instructed to assure that hospitals comply with this requirement.

Further justification for the intermediary's position is found in 42 C.F.R. § 405.452(d)(6) which defines "charges" as follows:

> Charges refer to the regular rates for various services which are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services.

The statutory justification for this regulation is 42 U.S.C. § 1395x(v)(1)(A) which provides that the cost of services includes both direct and indirect costs and that the regulations formulated to execute the program insure that the costs of

providing services to beneficiaries not be borne by nonbeneficiaries while also insuring that the costs of services to nonbeneficiaries not be borne by the Medicare program.

St. Marys appealed the intermediary's actions with respect to fiscal years 1978 and 1979, contending that grossing-up of the charges to SLS patients diluted the cost of providing services to Medicare beneficiaries. The hospital offered to use an accounting method different than the revenue offset previously used and also offered an in-house study of the SLS program which showed that the SLS services were less extensive than those provided to the hospital's own patients.

St. Marys received a hearing before a Provider Reimbursement Review Board (PRRB) in November, 1982. The hospital offered a study of its laboratory department done by the independent accounting firm of Ernst & Whinney in January, 1982. Concentrating on an SMAC, a series of blood tests done simultaneously by machine that made up almost 50% of the SLS tests, the study concluded that the SMAC for hospital patients involved twelve separate steps. Included were the original order for the test, the collection of the specimen from the patient by laboratory personnel, initial paperwork and preparation of the specimen for testing (which involved centrifuge use, and, sometimes refrigeration), the technical component (that is, the actual testing by machine), recording of results and billing. According to the study only three of the steps, including the technical component, were performed by hospital personnel or involved the use of hospital equipment when the SMAC was done for SLS patients. The preparation of the specimen, along with collection of the specimen and billing the patient, were done by the clinic, hospital or ordering doctor who made use of the SLS service. The study also purported to show that repeat testing (because of anomalous results) was necessary almost twice as

often for hospital patients as it was for SLS patients, thus increasing the cost differential between the two. The cost differential was calculated to be $2.19 in 1979 and $2.31 in 1978. The cost of an SLS test ranged between 68% and 77% of the cost of a test on a hospital patient.

The PRRB concluded after the hearing that charges to SLS patients should be grossed up in accordance with the actions of the intermediary. Citing "several discrepancies in the [Ernst & Whinney] study," the Board decided that the provider had failed to establish the cost of SLS services. The Board also noted, in support of its finding of inaccuracy of the study, that the provider never used the study to adjust its charges to SLS patients, and that the provider's witness conceded that charges for SLS services failed to meet the costs of the service. The Board concluded:

> The Board finds, as in *PRRB Decision 82-D104*, that the cost computations for the services rendered to non-provider patients would have to be accurate and verifiable before their use could be considered as a more sophisticated method of cost apportionment.

Thus, the intermediary's adjustments for years 1978 and 1979 were affirmed. The Deputy Administrator of the HCFA declined to reverse, modify or affirm the decision of the PRRB. The PRRB decision is, in accordance with 42 U.S.C. § 1395oo(f)(1), the final decision of the Secretary of the Department of the Health and Human Services.

St. Marys timely filed for review of that decision with this Court.

MEMORANDUM

St. Marys poses four questions in support of its appeal to overturn the Secretary's final action. They are:

1. Did the Secretary err in deeming the tests for SLS and hospital patients identical for purposes of apportionment?

2. Did the Secretary err in disallowing significant laboratory costs during the two years in question by grossing up the costs of SLS charges?

3. Was Intermediary Letter 80-8 a substantive change in Medicare policy which should have been published pursuant to the Administrative Procedure Act, Title 5, United States Code?

4. Was application of Intermediary Letter 80-8, which was promulgated after the accounting years in question in this case, violative of the Fifth Amendment's due process clause?

The Court finds no merit whatsoever in the arguments offered in support of St. Marys' position on questions three and four above. Without belaboring the point, it is clear that regulations predating 1978, particularly 42 C.F.R. § 405.452(d)(6) (formerly subsection (d)(4)), required that charges be reflective of costs and that charges for identical services be equalized or grossed-up before apportionment between Medicare and non-Medicare patients. It is equally clear that the regulations execute the policy enunciated in 42 U.S.C. § 1395x(v)(1)(A) that charges to Medicare beneficiaries not subsidize the services provided to other patients. The explicit application of the grossing-up procedure to laboratory services such as those at issue here may not have been apparent before Intermediary Letter 80-8. However, the pre-existing regulations did not preclude grossing-up of laboratory service charges and, in fact, implicitly required it. Therefore, intermediary Letter 80-8 was a clarification of pre-existing law rather than a substantive change, and retroactive application does not implicate due process prohibitions.

However, the arguments advanced in support of one and two above are, in important respects, meritorious and require reversal of the decision of the Provider Reimbursement Review Board.

The Board's decision is based on the proposition that, because the cost study offered by St. Marys was inaccurate in some respects, the intermediary's position with respect to grossing-up the charges to SLS patients had to be affirmed. The scope of review of the Board's factual determinations is limited. A finding based on substantial evidence in the record must be affirmed. 5 U.S.C. § 706.

This Court cannot seriously question the Board's conclusion that the Ernst & Whinney cost study was inaccurate in some respects. There is evidence in the record to support the Board's conclusion that the costs of the pathologist who supervised the laboratory operations had not been properly allocated to the SLS service. St. Marys attempted to correct this oversight in a post-hearing submission. There is also evidence in the record that the costs of supervising the SLS couriers had not been properly accounted for; that the costs of collecting specimens may have been overstated because of a failure to take into account the fact that multiple tests might be performed on a single specimen; that the period of the Ernst & Whinney study might not be representative of the period in question; and, arguably, that costs relating to tests done on St. Marys' patients at Methodist Hospital may have been improperly allocated. Although it is arguable that St. Marys' witnesses resolved some or all of these questions, the Board was not obliged to accept the testimony. The Court must conclude that the questions were raised and that the evidence of possible inaccuracy is in the record. Thus, the Board's decision concerning inaccuracy cannot be overturned.

However, there is one fact in the record which is not in dispute. That fact is that the SLS tests were not as costly, in fact were significantly cheaper, to perform than the same tests done for hospital patients. There is room for disagreement with the Ernst & Whinney study at the bottom line where a particular dollar figure is placed on the SLS and hospital patient costs. There can be no disagreement that, for practical purposes, the only things in common between the two were the technical component of the test, some minor paperwork, and the name of the test. In the collection, transporting, and preparation of the specimen, there were different procedures and the hospital's costs were lower for SLS patients.

Although prior to the hearing, the intermediary contested this fact, nothing presented to the Board or to this Court seriously questions this aspect of the Ernst & Whinney study. In fact, as the Court reads the Board's decision, this fact was implicitly accepted by the Board. The Board merely stated that, in order to accept the study's cost computations as a more sophisticated method of apportionment, the computations would have to be more accurate. If it had not been established that the procedures were substantively different, there would have been no reason to rule on the accuracy of the cost computations. Also in the record is the testimony of the intermediary's representative, who stated that the reason grossing-up was required was because a given test for SLS patient had the same name as that for the hospital patient. He testified that, as he understood Intermediary Letter 80-8, grossing-up was required whether the costs were different or not.

This Court concludes that the Board's decision is based on incorrect reading of the law. The Intermediary Letter, the clearest statement with regard to the law in question, requires grossing-up of charges only for *similar* services. The

touchstone of the law – the ultimate justification for the cost finding and apportionment regulations – is the Congressional mandate that neither Medicare program funds nor charges to non-Medicare patients subsidize the other. 42 U.S.C. 1395x(v)(1)(A). *Northwest Hospital, Inc. v. Hospital Service Corp.*, 687 F.2d 985, 989 (7th Cir. 1982). Since it is abundantly clear that SLS services are less costly than the charges to hospital patients for the same test because the procedures are substantively different, it is obvious that grossing-up of the charges violates the Congressional mandate. Under these circumstances, there is utterly no doubt that grossing-up will cause SLS clients to pay some of the Medicare beneficiaries.

In this regard, it must be pointed out that the decision on which the Board relied for its decision, *Lake Region Hospital v. Blue Cross Assoc/Blue Cross/Blue Shield of Minnesota*, PRRB Dec. No. 82-D-14, CCH Medicare and Medicaid Guide ¶ 32021 (1982), is inapplicable. Although on point with respect to the question presented (apportionment of Laboratory services), the Board held in *Lake Region* that the provider's study failed to substantiate that there was a difference in cost of services between those provided to hospital patients and others. Here, the study indicated a clear difference in cost. Only the extent of the difference is debatable.

Much more on point is *St. Mary's Medical Center (Knoxville, Tenn.) v. Blue Cross Assoc./Blue Cross & Blue Shield of Tennessee*, PRRB Dec. No. 79-D79, CCH Medicare and Medicaid Guide, ¶ 30,432 (1980). In that case, the Board disapproved of grossing-up of charges when the provider's study showed that laboratory services for outside patients (which were charged at 35% of the charge for hospital patients) were less extensive. The study showed only two of the nine steps required for hospital patients needed to be performed for non-hospital patients. The Board explicitly found the provider's study to be accurate and also allowed a revenue offset

accounting method because the study showed that the revenues exceeded costs. In the case before the Court, the Board found fault with the accuracy of the study with respect to actual cost figures and also determined, correctly, that costs exceeded revenues, thus precluding a revenue offset. Nevertheless, in this case the most important factor – the dissimilarity of the service provided and the existence of a cost differential – is present. This case is, therefore, much closer to *St. Mary's (Knoxville)* than it is to *Lake Region.*

Therefore, the Court is compelled to conclude that the decision of the PRRB and the Secretary is contrary to law. While the Board's decision that the Ernst & Whinney study was inaccurate is due deference because it was based on substantial evidence, the Board incorrectly concluded that grossing-up was proper. Because the hospital has shown that the procedures used on SLS patients are dissimilar to, and less costly than, the procedures for the hospital patients, the law clearly requires that the reimbursement process take the difference into account.

This decision is not only required by the Congressional mandate, but has a certain amount of logical force as well. The hospital can be expected to react to the intermediary's actions by reassessing the SLS program. It could well conclude that, given the added cost of lower Medicare reimbursement, the SLS program should be discontinued. Competitive factors may preclude the hospital from raising the SLS charge enough to make up for the loss. If the program is discontinued, the costs of the laboratory will fall more onerously on the hospital patients, including Medicare beneficiaries. While the hospital must be required to properly attribute the true costs of SLS so that the Medicare program does not subsidize it, the law does not appear to forbid competitive pricing of dissimilar services.

On remand, the Board may resolve the inaccuracies in the Ernst & Whinney study in accordance with generally accepted accounting principles. As long as there is a cost differential, the determination of the specific costs and the method of cost apportionment must be left to the Board's expertise. The record, particularly the testimony of the intermediary's witness, conclusively shows that the findings of the study can be audited and that the inaccuracies can be resolved.

After resolving any problems with the cost accounting of the laboratory, the Board may choose to resolve the question of proper apportionment in whatever manner will insure that cross subsidization does not occur. St. Marys' suggestion – removal of the SLS costs from the laboratory cost center – need not be accepted. The Court has noted St. Marys' submission of material concerning the disposition of an almost identical case, that of Madison General Hospital which, coincidentally, is located only a few blocks from St. Marys (*PRRB Case No. 81-307*). It appears that a settlement in that case was reached which allowed for a modification of the grossing-up approach. As the Court understands it, the charges to nonpatients were grossed-up only to the extent that such charges reflected the same mark-up over cost as the mark-up of the cost of services to hospital patients. Although the Court does not mean to require such a process, it would appear to meet the mandate of Congress in 42 U.S.C. § 1395x(v)(1)(A) and, at the same time, comply with the objective of 42 C.F.R. § 405.452(d)(6) that there be a consistent cost-to-charge relationship.

CONCLUSION

The record indicates that there is a significant difference in procedures and costs between tests given to SLS patients and other hospital patients. The record also indicates support

for the Board's decision that the provider's study contained inaccuracies. Congress has mandated that there be no cross subsidization between Medicare and non-Medicare patient charges. In order to fulfill this mandate, the Board in this case must resolve the inaccuracies and thereafter adopt a cost apportionment method that insures no cross subsidization. In this case, grossing-up of SLS charges to the level of the charges to hospital patients undoubtedly causes the costs of Medicare patients to be borne by others.

Accordingly,

ORDER

IT IS ORDERED that the decision of the Secretary is REVERSED and the matter REMANDED for further proceedings not inconsistent with this opinion.

Entered this 24th day of December, 1983.

BY THE COURT:

JOHN C. SHABAZ
District Judge

Provider Reimbursement Review Board
Hearing Decision
83-D42

Provider–	St. Mary's Hospital Medical Center Madison, Wisconsin	Date of Hearing– November 9, 1982
	v	
Intermediary–	Blue Cross and Blue Shield Association/ Blue Cross/Blue Shield United of Wisconsin	Cost Reporting Period Ending– December 31, 1978 and 1979

Case No. 81-235

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ISSUE:

Where a hospital provides laboratory services to non-provider patients at a reduction from standard charges, should such charges be grossed up to the standard charges for use in apportioning laboratory costs among program beneficiaries and other users of the department?

SUMMARY OF FACTS:

The Provider is a 390-bed, short-term, acute-care, nonprofit hospital located in Madison, Wisconsin. For the fiscal years at issue, December 31, 1978 and December 31, 1979, the hospital's overall occupancy rate was approximately 80 percent and its Medicare utilization rate was approximately 34 percent. The Intermediary issued a Notice of Program Reimbursement on November 5, 1980. The Provider filed a request for hearing under the provisions of 42 CFR 405.1835ff and met the jurisdictional requirements of these regulations. The amount of Medicare reimbursement in dispute is $123,471 for 1978 and $148,692 for 1979.

Since 1972, the Provider, in cooperation with Methodist Hospital of Madison, has sold laboratory services to commercial accounts such as private physicians, clinics and small hospitals. This arrangement became known as Shared Laboratory Services (SLS). The Provider sells laboratory services to non-Provider patients at a lower charge per service than it makes to hospital patients.

In its cost report for fiscal year ended December 31, 1978 and previous years, the Provider offset the revenues from the sale of laboratory services to nonprovider patients from total laboratory costs and eliminated the charges assessed these patients from department statistics. For the fiscal year ended December 31, 1979, the Provider's original cost report reflected the shared laboratory sales as an outpatient revenue for cost apportionment purposes. The Intermediary grossed up the hospital's shared laboratory revenues to equal what would have been charged if the shared services had been charged at the same rate as was charged for the same service to hospital patients. These grossed-up charges were then included with all other laboratory charges for both fiscal years ended December 31, 1978 and December 31, 1979. For the Provider's fiscal year ended December 31, 1978, the

revenues offset reducing laboratory costs was also eliminated.

Provider's Contentions:

The Provider contends that the sale of laboratory services to the commercial accounts has always been economically advantageous to the Provider. Because much of the equipment and personnel required to operate its laboratory facility were underutilized, the SLS program allowed the Provider to spread the direct costs incurred in furnishing the laboratory services to commercial accounts, thereby reducing the cost of providing such services to all of the Provider's patients including Medicare beneficiaries. The SLS portion of the total laboratory procedures was 21 percent in 1978 and 18 percent in 1979.

The Provider further contends that in order to continue to receive the economic advantages resulting from sales of laboratory services to commercial accounts, it has become increasingly necessary to compete with the private commercial laboratories. Because the services offered by these commercial laboratories are much less extensive than those offered by the Provider to its own patients, their prices are far less than the Provider's usual charges to its own patients. Therefore, the lower prices charged by the commercial laboratories and SLS reflect the limited services associated with these laboratory tests.

Initially, the Provider contended that by offsetting the revenue received from the sale of laboratory services to non-provider patients from total department costs or, in the alternative, by offsetting the cost of providing such outside laboratory services from department costs, a proper apportionment of the cost of providing laboratory services to the Provider's patients could be made between Medicare and non-Medicare patients. In its post-hearing brief, however, the Provider discounted the revenue-offset approach.

In support of its position, the Provider retained a CPA firm to conduct an industrial work measurement study to ascertain whether the services rendered to SLS clients were markedly different from those furnished the Provider's patients. The study was also designed to ascertain the actual cost of performing the SLS procedures so that it could be compared with SLS revenues, which would support an apportionment method based on a revenue offset. The study was conducted during the week of January 25, 1982, with one test, the SMAC test, being selected for analysis because it accounted for approximately 43 to 46 percent of total SLS test volume. The Provider contends that the study concluded that substantial differences existed between the laboratory services provided to the Provider's patients and the laboratory services provided to its SLS clients. The performance of laboratory tests for SLS clients was less expensive, and the difference between revenues and expenses for SLS clients was less than 1.6 percent of total laboratory revenues from all sources.

The Provider takes the position that the costs are nonallowable costs and that the SLS clients do not constitute patients of the Provider. The Provider further notes that this position is consistent with PRRB Decision *79-D79*, where the Board held that the Provider need only offset the revenue received from the pathologists against the costs of the laboratory department rather than gross up laboratory charges in the apportionment process. It held that a revenue offset was appropriate where the revenue realized from the nonallowable activity exceeded costs.

Accordingly, the Provider contends that the Board should allow the Provider to offset actual SLS costs as determined by the cost study from the total laboratory costs.

Intermediary's Contentions:

It is the Intermediary's position that this appeal presents a cost apportionment problem pursuant to 42 CFR 405.452(b)(1),

i.e., how to apportion the costs of the Provider's laboratory, an ancillary department, among its users. The methodology for apportioning ancillary department costs is set forth in 42 CFR 405.452(b)(1). Patient charges, the statistic used to apportion ancillary costs, is defined in 42 CFR 405.452(d)(4) as "the regular rates for various services which are charged to both beneficiaries and other paying patients who receive the services." The charges for the so-called outside services, according to the Intermediary, properly belong in the category of "other paying patients because the hospital has the same responsibility for accurately performing and analyzing all procedures.

In analyzing the statement in the definition of charges that "charges be related to the cost of services," the Intermediary points out that, under Medicare, providers have a great deal of flexibility in how they set their charge level. The profit margin need not be uniform for every single ancillary department. However, the Intermediary believes that a consistent rate between charges and costs is reasonably required within a given ancillary department. The Intermediary does not believe Medicare policy would permit any kind of a charge differential based upon who the patient is. Therefore, the Intermediary contends that the uniform charge requirement is supported by the Medicare regulations, Section 2202.4 of the Provider Reimbursement Manual, as well as Intermediary Letter 80-8. The Intermediary also refers to the letter from the Bureau of Program Policy, Health Care Financing Administration, which specifically addressed the dispute in *PRRB Decision 79-D79*, indicating that a hospital must gross up or apply standard charges for similar services provided by a department to provider and nonprovider patients. In addition, the Intermediary states that not only did the Provider not use uniform charges but, also, it did not apply a consistent markup between cost and charges.

The Intermediary rejects the Provider's alternative suggestions for the use of a cost or revenue offset. The Intermediary contends that a revenue offset is appropriate only in the cost-finding process when there is a cost center which contains both allowable and nonallowable Medicare costs. The Intermediary also rejects any reliance on Section 2108.10 of the Provider Reimbursement Manual, pointing out that section applies only to those costs related to the provision of physician services to nonprovider patients. It does not pertain to services rendered by the provider for which the provider renders a charge.

The Intermediary then contends that, even if the Board rejects the Intermediary's argument that uniform charges must be used for apportionment, the Provider must convincingly demonstrate, through use of a more sophisticated method of costing laboratory services, that there is a justifiable charge differential through auditable and verifiable data. The Intermediary contends that the Provider's study will not satisfy the requirements of 42 CFR 405.453(a) and (c). Some of the problems cited by the Intermediary are as follows:

1. The study was not conducted to independently develop the costs of procedures both for hospital inpatients and SLS patients. The going-in premise of the study was that SLS procedures were less costly than hospital procedures.

2. Assignment of general overhead and supervisory time understated SLS costs by not accurately allocating overhead-type costs between SLS and hospital patients.

3. The Provider never used the results of the study to set or adjust its charges to either inpatients or SLS patients.

4. The Provider's management appeared to have tremendous reluctance in accepting the study as being accurate.

5. The study was conducted long after the fiscal years in dispute were completed and was never validated by subsequent reviews.

The Intermediary contends that the Provider's study fails to justify the charge differential and requests the Board to consider its opinion in *PRRB Decision 82-D104*, where the Board found the Provider's study did not substantiate that there was a difference in the cost of providing services to nonprovider patients.

CITATION OF APPLICATION LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. *Law – Title XVIII of the Social Security Act*
   Section 1861(v)(1)(A) – Reasonable Cost

2. *Regulations – 42 CFR 405, Subpart D*
   a. Section 405.451 – Cost Related to Patient Care
   b. Section 405.452(d) – Determination of Costs of Services to Beneficiaries: Periods Starting after December 31, 1971
   c. Section 405.452(d), (1), (2), (3), (4) – Determination of Cost of Services to Beneficiaries: Definitions; Apportionment, Routine Services, Ancillary Services, Charges
   d. Section 405.453 – Adequate Cost Data and Cost Finding

3. *Program Instructions–Provider Reimbursement Manual, HIM-15*
   a. Section 2102.3 –Costs not Related to Patient Care
   b. Section 2202.3 –Apportionment
   c. Section 2202.4 –Charges
   d. Section 2203 –Provider Charge Structure as Basis for Apportionment
4. *Other*
   Part A Intermediary Letter 80-8, March, 1980

CONCLUSIONS AND FINDINGS:

The Provider Reimbursement Review Board, after consideration of the facts, parties' contentions, testimony elicited at the hearing, and the post-hearing submittals, concludes and finds that the charges for the services rendered to non-provider patients should be grossed up to the same level of the charges that the hospital used for services to its patients, and these charges should be included in total charges in the apportionment process.

The Board finds that the Provider's study did not establish the cost of providing services to non-Provider patients for the years 1978 and 1979. In support of this, several discrepancies in the study were noted by the Board during the hearing. Testimony elicited at the hearing revealed that the Provider's management (Tr. 44-45, 65) and its CPA firm consultants (Tr. 222) indicated a lack of confidence that the cost study was an accurate reflection of these costs. Further, evidence submitted after the hearing by the Provider indicates that the pathologists' fees were not properly allocated in the cost computation shown in the material initially submitted to the Board.

The evidence also indicates that the Provider never used the results of the study to adjust its charges to either inpatients or SLS patients. The post-hearing submittal reveals that SLS charges were established initially on an arbitrary basis, and consistent markups were not applied to them in later years. For example, in August 1977, charges for SLS services were increased at varying rates, but the charges for the SMAC test remained unchanged. On May 1, 1979, a variable price adjustment was made, averaging a 22.6 percent increase based on a comparison of other commercial laboratories. The Provider never used the results of the study to adjust its charges to either inpatients or SLS patients. Moreover, the CPA's testimony indicated that charges for SLS services were insufficient to meet the cost of the services (Tr. 177).

The Board finds, as in *PRRB Decision 82-D104*, that the cost computations for the services rendered to nonprovider patients would have to be accurate and verifiable before their use could be considered as a more sophisticated method of cost apportionment.

DECISON

The Intermediary's adjustments are affirmed. The laboratory charges to the non-Provider patients must be grossed up to the standard charges for use in apportioning laboratory costs among program beneficiaries and other users of the department.

Board Members Participating:

Thomas M. Tierney
James Houdek, Jr., CPA
Bette A. Kraus
Paul Morton Ganeles, CPA
Richard A. Dudgeon, CPA

FOR THE BOARD:

March 15, 1983

Thomas M. Tierney
Chairman

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
Chicago, Illinois 60604

March 1, 1985

Before:
Hon. WALTER J. CUMMINGS, Chief Judge
Hon. JESSE E. ESCHBACH, Circuit Judge
Hon. LUTHER M. SWYGERT, Senior Circuit Judge

ST. MARYS HOSPITAL MEDICAL CENTER Plaintiff-Appellee, No. 84-1443	) Appeal from the) United States District) Court for the Western) District of Wisconsin.
v.	) No. 83 C 445
MARGARET M. HECKLER, Secretary, Department of Health and Human Services, Defendant-Appellant	) John C. Shabaz, Judge

ORDER

On consideration of the petition for rehearing and suggestion for rehearing *en banc* filed in the above-entitled cause by plaintiff St. Marys Hospital Medical Center, no judge in active service has requested a vote thereon, and all of the judges on the orginal panel have voted to deny a rehearing. Accordingly,

IT IS ORDERED that the aforesaid petition for rehearing be, and the same is hereby, DENIED.

JUDGEMENT—ORAL ARGUMENT
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
Chicago, Illinois 60604

January 22, 1983

Before:
Hon. WALTER J. CUMMINGS, Chief Judge
Hon. JESSE E. ESCHBACH, Circuit Judge
Hon. LUTHER M. SWYGERT, Senior Circuit Judge

ST. MARYS HOSPITAL MEDICAL CENTER Plaintiff-Appellee, No. 84-1443 *v.* MARGARET M. HECKLER, Secretary, Department of Health and Human Services, Defendant-Appellant	) Appeal from the) United States District) Court for the Western) District of Wisconsin.) No. 83 C 445) Judge John C. Shabaz)

This cause was heard on the record from the United States District Court for the Western District of Wisconsin, – – Division, and was argued by counsel.

On consideration whereof, IT IS ORDERED AND ADJUDGED by this Court that the judgement of the said District Court in this cause appealed from be, and the same is hereby REVERSED, with costs, in accordance with the opinion of this court filed this date.